

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0009530</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Harbor Crest Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																																																	
Address: <u>817 17th Street</u> <u>Fulton</u> <u>61252</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Whiteside</u>																																																			
Telephone Number: <u>(815) 589-3411</u> Fax # <u>(815) 589-4728</u>																																																			
IDPA ID Number: <u>36-2521635</u>																																																			
Date of Initial License for Current Owners: <u>07-06-66</u>																																																			
Type of Ownership:																																																			
<table><tr><td><input checked="" type="checkbox"/></td><td>VOLUNTARY,NON-PROFIT</td><td><input type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input checked="" type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501(c)(3)</u></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Other</td><td colspan="2"></td></tr></table>		<input checked="" type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input checked="" type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	IRS Exemption Code <u>501(c)(3)</u>		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other			<input type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other				
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		<input type="checkbox"/>	Other																																																
In the event there are further questions about this report, please contact: Name: <u>Patrick Parker, CPA</u> Telephone Number: <u>(563) 386-2727</u>		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Robert J. Gale</u></td><td></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Title) <u>Administrator</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Frank C. Ludgate, CPA</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>Doyle & Keenan, P.C.</u> <u>908 W. 35th Street, Davenport, IA 52806</u></td><td></td></tr><tr><td>(Telephone) <u>(563) 386-2727</u> Fax # <u>(563) 386-8730</u></td><td></td></tr><tr><td colspan="2"></td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Robert J. Gale</u>		Paid Preparer	(Title) <u>Administrator</u>		(Signed) _____	(Date) _____	(Print Name and Title) <u>Frank C. Ludgate, CPA</u>		(Firm Name & Address) <u>Doyle & Keenan, P.C.</u> <u>908 W. 35th Street, Davenport, IA 52806</u>		(Telephone) <u>(563) 386-2727</u> Fax # <u>(563) 386-8730</u>				MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																													
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Facility Name & ID Number Harbor Crest Home

0009530 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	15,683	8,352		24,035	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,683	8,352		24,035	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.39%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Meals on Wheels

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started 07/06/1966

J. Was the facility purchased or leased after January 1, 1978?

YES

☐

Date

NO

☒

K. Was the facility certified for Medicare during the reporting year?

YES

☐

NO

☒

If YES, enter number

of beds certified

and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/2005

Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Harbor Crest Home # 0009530 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	251,873	20,326		272,199	3,300	275,499	(13,555)	261,944			1
2	Food Purchase		155,404		155,404		155,404		155,404			2
3	Housekeeping	112,792	15,011		127,803		127,803		127,803			3
4	Laundry	56,903	9,137		66,040		66,040		66,040			4
5	Heat and Other Utilities			73,226	73,226		73,226	(4,191)	69,035			5
6	Maintenance	73,833	5,274	22,393	101,500		101,500		101,500			6
7	Other (specify):*											7
8	TOTAL General Services	495,401	205,152	95,619	796,172	3,300	799,472	(17,746)	781,726			8
	B. Health Care and Programs											
9	Medical Director					4,800	4,800		4,800			9
10	Nursing and Medical Records	1,069,151	83,631	26,442	1,179,224	3,000	1,182,224		1,182,224			10
10a	Therapy					3,520	3,520		3,520			10a
11	Activities	92,404	1,767		94,171	2,000	96,171		96,171			11
12	Social Services	56,239			56,239	2,000	58,239		58,239			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,217,794	85,398	26,442	1,329,634	15,320	1,344,954		1,344,954			16
	C. General Administration											
17	Administrative	70,033			70,033		70,033		70,033			17
18	Directors Fees											18
19	Professional Services			27,007	27,007	(18,620)	8,387		8,387			19
20	Dues, Fees, Subscriptions & Promotions			6,663	6,663		6,663	(75)	6,588			20
21	Clerical & General Office Expenses	44,414	5,511	16,410	66,335		66,335	(2,064)	64,271			21
22	Employee Benefits & Payroll Taxes			300,059	300,059	42,886	342,945		342,945			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,106	2,106		2,106		2,106			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,944	55,944	(42,886)	13,058		13,058			26
27	Other (specify):*			25,249	25,249		25,249	(25,249)				27
28	TOTAL General Administration	114,447	5,511	433,438	553,396	(18,620)	534,776	(27,388)	507,388			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,827,642	296,061	555,499	2,679,202		2,679,202	(45,134)	2,634,068			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Harbor Crest Home #0009530 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			36,917	36,917		36,917		36,917			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,902	7,902		7,902		7,902			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			44,819	44,819		44,819		44,819			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,116	46,116		46,116		46,116			42
43	Other (specify):* Lawsuit Settlement			30,000	30,000		30,000		30,000			43
44	TOTAL Special Cost Centers			76,116	76,116		76,116		76,116			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,827,642	296,061	676,434	2,800,137		2,800,137	(45,134)	2,755,003			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,555)	1		4
5	Telephone, TV & Radio in Resident Rooms	(4,191)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,064)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,375)	27		24
25	Fund Raising, Advertising and Promotional	(75)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Resident Loss	(1,874)	27		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (45,134)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (45,134)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY							
48		49		50		51	

Harbor Crest Home

ID# 0009530
Report Period Beginning: 01/01/2005
Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Harbor Crest Home # 0009530 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(13,555)	0	0	0	0	0	0	0	0	0	0	(13,555)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,191)	0	0	0	0	0	0	0	0	0	0	(4,191)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(17,746)	0	0	0	0	0	0	0	0	0	0	(17,746)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(75)	0	0	0	0	0	0	0	0	0	0	(75)	20
21	Clerical & General Office Expenses	(2,064)	0	0	0	0	0	0	0	0	0	0	(2,064)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(23,375)	0	0	0	0	0	0	0	0	0	0	(23,375)	27
28	TOTAL General Administration	(25,514)	0	0	0	0	0	0	0	0	0	0	(25,514)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,260)	0	0	0	0	0	0	0	0	0	0	(43,260)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1Schedule V		2Line	3Cost Per General Ledger	4Amount	5Cost to Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Harbor Crest Home # 0009530 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	CENTRAL BANK FULTON		X	Purchase Equipment	\$116.53	05/09/02	\$ 5,800	\$ 1,851	05/09/07	0.0750	\$ 189	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CENTRAL BANK FULTON		X	Line of Credit		10/27/05		135,000	10/27/06	0.0700	7,713	6
7												7
8												8
9	TOTAL Facility Related				\$116.53		\$ 5,800	\$ 136,851			\$ 7,902	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 5,800	\$ 136,851			\$ 7,902	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000		8	
		2001		9	
		2002		10	
		2003		11	
		2004		12	
				13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harbor Crest Home COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0009530

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,086 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		206,474	1965	\$ 12,001	1
2					2
3	TOTALS	206,474		\$ 12,001	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	51		1966	1966	\$ 222,212	\$ 4,444	50	\$ 4,444		\$ 205,965	4
5	53		1977	1977	383,024	9,575	40	9,575		275,541	5
6			1983	1983	24,741		15			24,741	6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1966	55,144		Various			55,144	9
10	Building Improvements			1968	9,316		Various			9,316	10
11	Building Improvements			1969	2,255		Various			2,255	11
12	Building Improvements			1973	320		Various			320	12
13	Building Improvements			1974	294		Various			294	13
14	Building Improvements			1976	871		Various			871	14
15	Building Improvements			1977	186,665		Various			186,665	15
16	Building Improvements			1978	7,585		Various			7,585	16
17	Building Improvements			1979	9,504		Various			9,504	17
18	Building Improvements			1980	9,275		Various			9,275	18
19	Building Improvements			1982	16,353		Various			16,353	19
20	Building Improvements			1983	1,155		Various			1,155	20
21	Building Improvements			1984	39,154		Various			39,154	21
22	Building Improvements			1985	13,610		Various			13,610	22
23	Building Improvements			1986	11,101		Various			11,101	23
24	building Improvements			1987	6,617		Various			6,617	24
25	Building Improvements			1988	15,937		Various			15,937	25
26	Building Improvements			1989	10,418		Various			10,418	26
27	Building Improvements			1990	3,281	107	Various	107		3,081	27
28	Building Improvements			1991	3,355	79	Various	79		3,316	28
29	Building Improvements			1992	3,422	209	Various	209		3,177	29
30	Building Improvements			1993	7,331		Various			7,331	30
31	Building Improvements			1994	1,600		Various			1,600	31
32	building Improvements			1995	2,519		Various			2,519	32
33	GFI Outlets			1996	2,373	237	10	237		2,254	33
34	Replace Concrete Entryway			1996	605	41	15	41		369	34
35	Air Conditioning			1997	872		7			872	35
36	Flooring			1997	719	71	10	71		641	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sidewalk	1997	\$700	\$70	10	\$70	\$	\$601	37
38	Storage Shed	1997	960	64	15	64		538	38
39	Exhaust Fans	1997	560		7			560	39
40	Smoke Detectors	1998	247	24	10	24		187	40
41	Replace Roof	1998	55,919	1,398	40	1,398		10,601	41
42	Expand East Patio	1998	2,660	133	20	133		997	42
43	Shower in West Basement	1998	2,526	127	20	127		895	43
44	Gutter & Downspout in Back	1998	399	20	20	20		142	44
45	Replace Floor Tile	1999	1,148	115	10	115		776	45
46	Replace Compressor	1999	976	98	10	98		620	46
47	Water Heater	1999	3,837	255	15	255		1,769	47
48	Bricks for Sign	2000	173	12	15	12		65	48
49	New Outlet	2000	523	27	20	27		145	49
50	Outdoor Fabric Awnings	2002	6,238	624	10	624		2,132	50
51	York Rooftop A/C Unit	2002	3,505	501	7	501		1,711	51
52	2003 Disposals of Fully Depreciated Items	2003	(1,619)					(1,619)	52
53	81 Gallon Water Heater	2004	5,034	503	10	503		753	53
54	21 4WT-B Smoke Detectors	2004	2,263	226	10	226		262	54
55	9 4WT-B Smoke Detectors	2005	2,703	180	10	180		180	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$1,140,380	\$19,140		\$19,140	\$	\$948,296	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 159,868	\$ 16,643	\$ 16,643	\$		\$ 125,017	71
72	Current Year Purchases	15,845	1,134	1,134			1,134	72
73	Fully Depreciated Assets	289,175					289,175	73
74								74
75	TOTALS	\$ 464,888	\$ 17,777	\$ 17,777	\$		\$ 415,326	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,617,269	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,917	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,917	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,363,622	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$
- Description:
-
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER CNA

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,250	\$	1
2	Cash-Patient Deposits	5,769		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,000)	210,866		3
4	Supply Inventory (priced at)	15,700		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,640		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 250,225	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	12,001		13
14	Buildings, at Historical Cost	1,140,380		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	464,888		16
17	Accumulated Depreciation (book methods)	(1,363,622)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 253,647	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 503,872	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 33,698	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,769		28
29	Short-Term Notes Payable	136,303		29
30	Accrued Salaries Payable	71,327		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Vacation	99,500		36
37	Other Accrued Expenses	13,520		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 360,117	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	548		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 548	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 360,665	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 143,207	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 503,872	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 411,533	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 411,533	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(268,326)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (268,326)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 143,207	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Harbor Crest Home # 0009530 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,510,636	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,510,636	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	13,555	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,555	23
	D. Non-Operating Revenue		
24	Contributions	6,690	24
25	Interest and Other Investment Income***	930	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,620	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,531,811	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	796,172	31
32	Health Care	1,329,634	32
33	General Administration	553,396	33
	B. Capital Expense		
34	Ownership	44,819	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	46,116	36
	D. Other Expenses (specify):		
37	Lawsuit Settlement	30,000	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,800,137	40
41	Income before Income Taxes (line 30 minus line 40)**	(268,326)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (268,326)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,956	2,080	\$ 55,003	\$ 26.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,806	10,591	223,798	21.13	3
4	Licensed Practical Nurses	9,007	9,625	160,656	16.69	4
5	CNAs & Orderlies	53,482	57,714	594,789	10.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,355	2,682	34,906	13.01	8
9	Activity Director	1,912	2,080	33,009	15.87	9
10	Activity Assistants	5,855	6,414	59,394	9.26	10
11	Social Service Workers	3,747	4,019	56,239	13.99	11
12	Dietician					12
13	Food Service Supervisor	1,977	2,080	42,045	20.21	13
14	Head Cook	5,338	5,873	64,997	11.07	14
15	Cook Helpers/Assistants	5,506	5,934	57,719	9.73	15
16	Dishwashers	10,143	10,833	87,112	8.04	16
17	Maintenance Workers	5,769	5,972	73,833	12.36	17
18	Housekeepers	13,207	14,047	112,792	8.03	18
19	Laundry	3,768	4,272	56,903	13.32	19
20	Administrator	1,804	2,080	70,033	33.67	20
21	Assistant Administrator	1,907	2,080	43,334	20.83	21
22	Other Administrative	76	76	1,080	14.21	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,615	148,452	\$ 1,827,642 *	\$ 12.31	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	60	\$ 3,300	1-5	35
36	Medical Director	120	4,800	9-5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	144	3,000	10-5	39
40	Physical Therapy Consultant	61	3,355	10a-5	40
41	Occupational Therapy Consultant	3	165	10a-5	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,000	11-5	44
45	Social Service Consultant	40	2,000	12-5	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	468	\$ 18,620		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	266	\$ 10,022	10-3	50
51	Licensed Practical Nurses	379	13,652	10-3	51
52	Certified Nurse Assistants/Aides	157	2,768	10-3	52
53	TOTAL (lines 50 - 52)	802	\$ 26,442		53

Facility Name & ID Number	Harbor Crest Home
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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
Robert J Gale	Administrator	0	\$ 70,033	Workers' Compensation Insurance		\$ 42,886	IDPH License Fee		\$ 746		
				Unemployment Compensation Insurance		9,516	Advertising: Employee Recruitment		901		
				FICA Taxes		136,814	Health Care Worker Background Check		852		
				Employee Health Insurance		153,024	(Indicate # of checks performed 22)				
				Employee Meals			NIADA		40		
				Illinois Municipal Retirement Fund (IMRF)*			LSN Dues		3,758		
				Physicals		705	Secretary of State of Illinois		20		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							MES Illinois		235		
							Dietary Manager's Association		111		
B. Administrative - Other											
Description			Amount				Less: Public Relations Expense		(75)		
			\$				Non-allowable advertising	(
							Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Doyle & Keenan	Accounting		\$ 7,203			\$	Out-of-State Travel		\$		
Consulting	See Sched XVIII		18,620								
Bush, Motto, Creen & Koury	Attorney		1,184								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL				TOTAL (agree to Sch. V, line 24, col. 8)			

*** Attach copy of IMRF notifications**

****See instructions.**

Ending:

12/31/2005

(See instructions.)

[illegible]

Facility Name & ID Number Harbor Crest Home

0009530

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,121 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 46,116
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 13,555
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Doyle & Keenan, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.